DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 2 MR

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.151

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ [illegible]
b. FFY 2003 $ 3.87 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Addendum to Attachment 3.1-A, Page 13(d).4
Attachment 4.19-B, Page 24.1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
new

10. SUBJECT OF AMENDMENT:
Reimbursement for Mental Health Rehabilitation Services: Other Programs Licensed/Certified by the New Jersey Governmental Agencies

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Exempt pursuant to 7.c of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME: Christine L. Harris

14. TITLE: Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Division of Medical Assistance and Health Services
P.O. Box 712, 126
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 27 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR 01 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME: Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

As per State letter of 2/24/03, the original HCFA179 has been revised and replaced.
New pages have also been submitted and approved.
They are Addendum to Attachment 3.1-A page (d).4, Attachment 4.19-B page 24.1c

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

13(d).4 Rehabilitative Services:

Community Mental Health/Behavioral Health Rehabilitation Services

Limited to services provided under the treatment component of EPSDT to Medicaid/NJ KidCare—Plan A children who have been determined in need of this service in a setting that is appropriate to the child's age and mental, behavioral or emotional condition.

Limited to services contained in the child's treatment plan and that are provided in residential child care facilities, children's group homes, community psychiatric residences for youth, or other community based treatment programs licensed or certified by a State agency.

Community mental health rehabilitation services include any medical, rehabilitative or remedial services, provided through these programs, that are necessary for maximum reduction of the mental, behavioral or emotional problem and restoration of the beneficiary's best possible functional level. Services include, but are not limited to, psychiatric and psychological services, psychotherapy, counseling, behavioral modification and management, medication administration and management, treatment for drug and alcohol dependency or abuse, development of activities of daily living, and related nursing and mental health services.

Supersedes 00-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Mental Health Rehabilitation Services
Other Programs for Children Licensed/Certified by New Jersey Governmental Agencies

For programs certified by non-Department of Human Services state governmental agencies, services for youth/young adults will be reimbursed on a fee-for-service basis for each day of service based upon the non-Department of Human Services state governmental agency's cost of providing services. This cost will include only Medicaid-allowable costs. Rates will not include the cost of room and board. This methodology will include time studies that encompass all categories of provider personnel to determine the portion of time that provider personnel expend in the performance of Medicaid allowable activities. The resulting percentage will be applied to the non-Department of Human Services' state governmental agency's cost of providing services to calculate the total Medicaid-allowable costs of each provider in a base year.

The base-year average per diem cost in the base year will be calculated for each residential and day treatment provider. The initial payment rate for each type of provider will be the weighted average per diem cost for that type of provider, trended to the initial payment period. At the end of years one and two, an inflation factor will be applied to trend the rates to the current period. Adjustments to the rate will also be made based upon corrections to base-year costs. Rates will be re-based every three years.

New